

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

10089

63-041204

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 24 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b Life	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION E/R To City Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE BIELICKI		DATE OF DEATH Month Day Year 10 8 63	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/2/63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
13a. FATHER'S NAME Harold Bielicki		13b. MOTHER'S MAIDEN NAME Seymour BIELICKI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 491X		17. INFORMANT Address Virginia Bielicki 2007 MENARD	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ruth Queen		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 10-9-63		23. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	
23a. DATE 10-11-63		23d. LOCATION (City, town, or county) St. Louis County, Mo.	
24. FUNERAL DIRECTOR Mc LAUGHLIN FUNERAL HOME 2301 LA VETTE		25. DATE RECD. BY LOCAL REG. OCT 10 1963	
26. REGISTRAR'S SIGNATURE Rosal Smith, M.D.			

(Licensed Embalmer's Statement on Reverse Side)

500-10-000

8001

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____
Licensed Embalmer No. 4550
P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.